

		FOR OFF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0036632</u></p> <p>Facility Name: <u>COUNTRYSIDE HEALTHCARE CENTER</u></p> <p>Address: <u>1635 EAST 154TH ST.</u> <u>DOLTON</u> <u>60419</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 647-1717</u> Fax # <u>(847) 647-0222</u></p> <p>IDPA ID Number: <u>36-3730831</u></p> <p>Date of Initial License for Current Owners: <u>11/01/90</u></p> <p>Type of Ownership:</p> <table><tr><td><input type="checkbox"/></td><td>VOLUNTARY,NON-PROFIT</td><td><input checked="" type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td>IRS Exemption Code</td><td></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other</td></tr><tr><td></td><td></td><td><input checked="" type="checkbox"/></td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Other</td><td></td><td></td></tr></table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/>	VOLUNTARY,NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL	<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other			<input checked="" type="checkbox"/>	"Sub-S" Corp.					<input type="checkbox"/>	Limited Liability Co.					<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other			<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>SHERWIN I. RAY</u></td></tr><tr><td>(Title) <u>PRESIDENT</u></td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td></tr><tr><td colspan="2"><p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p></td></tr></table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>SHERWIN I. RAY</u>	(Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	<p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	
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Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER

0036632 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>100</u>	Skilled (SNF)	<u>100</u>	<u>36,500</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>97</u>	Intermediate (ICF)	<u>97</u>	<u>35,405</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>197</u>	TOTALS	<u>197</u>	<u>71,905</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>4,419</u>	<u>4,419</u>	8
9	SNF/PED					9
10	ICF	<u>61,953</u>	<u>298</u>		<u>62,251</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>61,953</u>	<u>298</u>	<u>4,419</u>	<u>66,670</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.72%

D. How many bed-hold days during this year were paid by Public Aid? 1,360 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 11/1/90

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 11/1/90 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 12 and days of care provided 4,379

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number

COUNTRYSIDE HEALTHCARE CENTER

#

0036632

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

Page 3

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	174,538	37,246	11,582	223,366		223,366	6,970	230,336			1
2	Food Purchase		239,921		239,921		239,921	(631)	239,290			2
3	Housekeeping	129,644	25,964		155,608		155,608		155,608			3
4	Laundry	71,056	17,143		88,199		88,199		88,199			4
5	Heat and Other Utilities			108,916	108,916		108,916	254	109,170			5
6	Maintenance	49,804	32,812	15,816	98,432		98,432	10,310	108,742			6
7	Other (specify):*			9,739	9,739		9,739		9,739			7
8	TOTAL General Services	425,042	353,086	146,053	924,181		924,181	16,903	941,084			8
	B. Health Care and Programs											
9	Medical Director			2,500	2,500		2,500		2,500			9
10	Nursing and Medical Records	1,435,062	81,493	2,181	1,518,736		1,518,736	36,070	1,554,806			10
10a	Therapy	56,212	696	54,150	111,058		111,058	49	111,107			10a
11	Activities	92,775	23,680		116,455		116,455		116,455			11
12	Social Services	325,702		1,189	326,891		326,891		326,891			12
13	Nurse Aide Training											13
14	Program Transportation			47	47		47		47			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,909,751	105,869	60,067	2,075,687		2,075,687	36,119	2,111,806			16
	C. General Administration											
17	Administrative	132,444		244,000	376,444		376,444	(165,391)	211,053			17
18	Directors Fees											18
19	Professional Services			184,971	184,971		184,971	(110,437)	74,534			19
20	Dues, Fees, Subscriptions & Promotions			35,642	35,642		35,642	(6,133)	29,509			20
21	Clerical & General Office Expenses	153,749	20,349	192,324	366,422		366,422	(88,275)	278,147			21
22	Employee Benefits & Payroll Taxes			365,280	365,280		365,280		365,280			22
23	Inservice Training & Education			4,964	4,964		4,964	1,061	6,025			23
24	Travel and Seminar							952	952			24
25	Other Admin. Staff Transportation			560	560		560	3,536	4,096			25
26	Insurance-Prop.Liab.Malpractice			323,664	323,664		323,664	3,688	327,352			26
27	Other (specify):*							52,353	52,353			27
28	TOTAL General Administration	286,193	20,349	1,351,405	1,657,947		1,657,947	(308,646)	1,349,301			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,620,986	479,304	1,557,525	4,657,815		4,657,815	(255,624)	4,402,191			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT XVIII B 35-2	7,200	
	REPAIRS & MAINTENANCE	4,382	
		0	11,582
3	HOUSEKEEPING		
		0	
		0	0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE	0	
		0	0
5	HEAT & OTHER UTILITIES		
	GAS HEAT	27,390	
	ELECTRICITY	64,901	
	WATER	16,105	
	CABLE TV - LOBBY	520	
		0	108,916
6	MAINTENANCE		
	GROUNDS MAINTENANCE	1,500	
	PAINTING & DECORATING	0	
	BUILDING REPAIRS	0	
	MAINTENANCE TRAVEL	0	
	EQUIPMENT MAINTENANCE & REPAIR	7,788	
	ELEVATOR MAINTENANCE & REPAIR	0	
	OUTSIDE LABOR	0	
	EXTERMINATING SERVICE	4,140	
	FIRE SERVICE	2,388	
		0	
		0	
		0	15,816
7	OTHER		
	SCAVENGER	9,356	
	SECURITY SERVICE	383	9,739
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES XVIII B 36-2	2,500	2,500

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING XVIII C 53-2		
	LABORATORY & XRAY EXPENSE	69	
	PURCHASED SERVICES	0	
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,112	
	PHARMACY CONSULTANT XVIII B 39-2	0	
	UTILIZATION REVIEW FEES XVIII B __-2	0	
	PHYSICIANS XVIII B __-2	0	
	PSYCHIATRIC XVIII B __-2	0	
	RN CONSULTANT XVIII B 38-2	0	
		0	
		0	2,181
10a	THERAPY		
	PHYSICAL THERAPY SERVICES	7,700	
	THERAPY CONTRACT SERVICES	22,325	
	OCCUPATIONAL THERAPY SERVICES	9,725	
	REHABILITATION CONSULTANT XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	7,200	
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0	54,150
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS	0	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0	
		0	0
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES	0	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0	
	SOCIAL WORKER XVIII B 45-2	1,189	
		0	1,189
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS XIII	0	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	47	47
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 244,000	244,000
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 25,259	
	ADMINISTRATIVE CONSULTANTS	XIX C 101,000	
	PROFESSIONAL FEES	XIX C 58,712	
		0	184,971
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 11,059	
	EMPLOYEE WANT ADS	XIX F 7,882	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 10,638	
	LICENSES & PERMITS	XIX F 3,467	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 1,138	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 1,308	35,642
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,190	
	EQUIPMENT REPAIR & MAINTENANCE	7,796	
	OUTSIDE CLERICAL SERVICES	120,115	
	PENALTIES / OVERDRAFT CHARGES	VI 18 42,597	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	17,534	
	MESSENGER SERVICE	3,092	
		0	192,324

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 197,657	
	UNEMPLOYMENT COMPENSATION	XIX D 40,277	
	WORKERS COMPENSATION INSURANCE	XIX D 43,882	
	HOSPITALIZATION INSURANCE	XIX D 76,647	
	EMPLOYEE BENEFITS - OTHER	XIX D 5,862	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	401-K EXPENSES	XIX D 955	
	CHICAGO HEAD TAX	XIX D 0	365,280
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	4,964	4,964
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	560	560
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	323,664	323,664
27	OTHER		
	BAD DEBTS	VI 24 0	
		0	0

GRAND TOTAL COLUMN 3 OTHER

1,557,525

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			53,588	53,588		53,588	180,902	234,490			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			67,632	67,632		67,632	573,288	640,920			32
33	Real Estate Taxes			409,613	409,613		409,613		409,613			33
34	Rent-Facility & Grounds			1,141,443	1,141,443		1,141,443	(1,129,280)	12,163			34
35	Rent-Equipment & Vehicles			27,882	27,882		27,882	9,421	37,303			35
36	Other (specify):*											36
37	TOTAL Ownership			1,700,158	1,700,158		1,700,158	(365,669)	1,334,489			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		118,783	41,347	160,130		160,130	(7,389)	152,741			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,857	107,857		107,857		107,857			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		118,783	149,204	267,987		267,987	(7,389)	260,598			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,620,986	598,087	3,406,887	6,625,960		6,625,960	(628,682)	5,997,278			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(16,320)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(631)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(42,597)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(11,059)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,138)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(48,248)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (120,143)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(508,539)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (508,539)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (628,682)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0036632

Report Period Beginning:01/01/2003

Ending:12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 388	6	1
2	MARKETING	(48,636)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(48,248)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER# 0036632

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	6,970	0	0	0	0	0	0	0	0	6,970	1
2	Food Purchase	(631)	0	0	0	0	0	0	0	0	0	0	(631)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	254	0	0	0	0	0	0	0	0	254	5
6	Maintenance	388	0	9,922	0	0	0	0	0	0	0	0	10,310	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(243)	0	17,146	0	0	0	0	0	0	0	0	16,903	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	36,070	0	0	0	0	0	0	0	0	36,070	10
10a	Therapy	0	(9,677)	9,726	0	0	0	0	0	0	0	0	49	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(9,677)	45,796	0	0	0	0	0	0	0	0	36,119	16
	C. General Administration													
17	Administrative	0	0	(165,391)	0	0	0	0	0	0	0	0	(165,391)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(110,437)	0	0	0	0	0	0	0	0	(110,437)	19
20	Fees, Subscriptions & Promotions	(12,347)	0	6,214	0	0	0	0	0	0	0	0	(6,133)	20
21	Clerical & General Office Expenses	(91,233)	0	2,958	0	0	0	0	0	0	0	0	(88,275)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,061	0	0	0	0	0	0	0	0	1,061	23
24	Travel and Seminar	0	0	952	0	0	0	0	0	0	0	0	952	24
25	Other Admin. Staff Transportation	0	0	3,536	0	0	0	0	0	0	0	0	3,536	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,688	0	0	0	0	0	0	0	0	3,688	26
27	Other (specify):*	0	0	52,353	0	0	0	0	0	0	0	0	52,353	27
28	TOTAL General Administration	(103,580)	0	(205,066)	0	0	0	0	0	0	0	0	(308,646)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(103,823)	(9,677)	(142,124)	0	0	0	0	0	0	0	0	(255,624)	29

Summary B

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGT.	NILES	MGTM/CLERICAL
				CAREPLUS REHAB	NILES	THERAPY
SEE ATTACHED SCHEDULE						
				COUNTRYSIDE		
				H/C LLC	NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 1,141,443	COUNTRYSIDE HEALTHCARE CENTER, LLC		\$	(1,141,443)	1
2	V	30	SL DEPRECIATION				182,943	182,943	2
3	V	32	INTEREST				517,809	517,809	3
4	V								4
5	V								5
6	V								6
7	V	10A	THERAPY SERVICES	54,149	CAREPLUS REHABILITATIVE SERVICES		44,472	(9,677)	7
8	V	39	ANCILLARY THERAPY	41,346			33,957	(7,389)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,236,938			\$ 779,181	\$ * (457,757)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONSULT FEES	\$ 7,200	CAREPLUS MGMT. INC.		\$	\$ (7,200)	15
16	V	17	MANAGEMENT FEES	244,000	" "			(244,000)	16
17	V	19	ADMIN. CONSULT FEES	101,000	" "			(101,000)	17
18	V	19	DATA PROCESS FEES	14,400	" "			(14,400)	18
19	V	21	CLERICAL FEES	118,200	" "			(118,200)	19
20	V	1	DIETARY SALARIES		" "		14,170	14,170	20
21	V	5	ELECTRICITY		" "		254	254	21
22	V	6	MAINT & REPAIRS		" "		434	434	22
23	V	6	MAINTENANCE SALARIES		" "		9,488	9,488	23
24	V	10	NURSING SALARIES		" "		36,070	36,070	24
25	V	10A	THERAPY SALARIES		" "		9,726	9,726	25
26	V	17	ADMIN SALARIES		" "		78,609	78,609	26
27	V	19	PROFESSIONAL FEES		" "		4,963	4,963	27
28	V	20	ADVERTISING		" "		6,214	6,214	28
29	V	21	TOTAL OFFICE		" "		31,148	31,148	29
30	V	21	CLERICAL SALARIES		" "		90,010	90,010	30
31	V	23	SEMINAR		" "		1,061	1,061	31
32	V	24	TRAVEL		" "		952	952	32
33	V	25	TRANSPORTATION		" "		3,536	3,536	33
34	V	26	INSURANCE		" "		3,688	3,688	34
35	V	27	EMPLOYEE BENEFITS		" "		52,353	52,353	35
36	V	30	DEPRECIATION (SL)		" "		14,279	14,279	36
37	V	32	INTEREST		" "		55,479	55,479	37
38	V	34	OFFICE RENT		" "		12,163	12,163	38
39	Total			\$ 484,800			\$ 424,597	\$ * (60,203)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENT	\$	CAREPLUS MGMT. INC.		\$ 9,421	\$ 9,421	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 9,421	\$ * 9,421	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGT ALLOCATIONS:								\$		1
2	SHERWIN I. RAY	PRESIDENT	ADMINISTRAT.	36.17		7	66.67	SALARY	21,680	17-7	2
3			FINANCE		SEE						3
4	JACOB BAKST	DIR. OPERATIONS	ADMINISTRAT.	21.57	ATTACHED	7	66.67	SALARY	21,680	17-7	4
5			CONSULTING		SCHEDULE						5
6	ROSLYN INDICH	CLERICAL	CLERICAL	2.54		7	66.67	SALARY	6,385	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 49,745		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CAREPLUS MANAGEMENT, INC.
Street Address 5940 W. TOUHY AVE.
City / State / Zip Code NILES, IL 60714
Phone Number (847) 647-1717
Fax Number (847) 647-0222

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	568,908	9	\$ 96,016	\$ 96,016	66,670	\$ 14,170	1
2	5	ELECTRICITY	CENSUS DAYS	568,908	13	2,165		66,670	254	2
3	6	MAINT & REPAIRS	CENSUS DAYS	568,908	13	3,701		66,670	434	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	568,908	13	80,966	80,966	66,670	9,488	4
5	10	NURSING SALARIES	CENSUS DAYS	568,908	13	307,794	307,794	66,670	36,070	5
6	10A	THERAPY SALARIES	CENSUS DAYS	568,908	13	82,996	82,996	66,670	9,726	6
7	17	ADMIN SALARIES	CENSUS DAYS	568,908	13	670,787	670,787	66,670	78,609	7
8	19	PROFESSIONAL FEES	CENSUS DAYS	568,908	13	42,352		66,670	4,963	8
9	20	ADVERTISING	CENSUS DAYS	568,908	13	53,021		66,670	6,214	9
10	21	TOTAL OFFICE	CENSUS DAYS	568,908	13	265,794		66,670	31,148	10
11	21	CLERICAL SALARIES	CENSUS DAYS	568,908	13	768,069	768,069	66,670	90,010	11
12	23	SEMINAR	CENSUS DAYS	568,908	13	9,053		66,670	1,061	12
13	24	TRAVEL	CENSUS DAYS	568,908	13	8,124		66,670	952	13
14	25	TRANSPORTATION	CENSUS DAYS	568,908	13	30,176		66,670	3,536	14
15	26	INSURANCE	CENSUS DAYS	568,908	13	31,470		66,670	3,688	15
16	27	EMPLOYEE BENEFITS	CENSUS DAYS	568,908	13	446,737		66,670	52,353	16
17	30	DEPRECIATION (SL)	CENSUS DAYS	568,908	13	121,842		66,670	14,279	17
18	32	INTEREST	CENSUS DAYS	568,908	13	473,414		66,670	55,479	18
19	34	OFFICE RENT	CENSUS DAYS	568,908	13	103,790		66,670	12,163	19
20	35	EQUIPMENT RENT	CENSUS DAYS	568,908	13	80,391		66,670	9,421	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,678,658	\$ 2,006,628		\$ 434,018	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	RELATED PARTY: COUNTRYSIDE HEALTHCARE CENTER, LLC						\$					\$	1		
2	CORUS BANK		X	MORTGAGE	\$50,182.00	05/98		4,343,980	2,924,589	06/05	0.0939	315,881	2		
3	COUNTRYSIDE PLAZA		X	JR MORTGAGE	\$17,307.38	05/98		1,978,877	1,838,058	05/08	0.0950	176,256	3		
4	CIB BANK		X	CAPITAL IMPROVEMENTS	\$11,374.45	02/01		540,000	255,874	02/06	PRIME+	25,132	4		
5	LOAN COST		X	LOAN COST	W/O OVER 5 YEARS			2,700	1,170	02/06		540	5		
	Working Capital														
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND	04/95		1,015,000			PRIME+	62,433	6		
7	A. I. CREDIT CORP.		X	INSURANCE FINANCING								5,199	7		
8													8		
9	TOTAL Facility Related				\$78,863.83		\$	7,880,557	\$	5,019,691			\$	585,441	9
	B. Non-Facility Related*														
10														10	
11														11	
12														12	
13														13	
14	TOTAL Non-Facility Related						\$		\$			\$		14	
15	TOTALS (line 9+line14)						\$	7,880,557	\$	5,019,691			\$	585,441	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

16	AMOUNT TO USE FOR RATE CALCULATION \$
----	---------------------------------------

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

COUNTRYSIDE HEALTHCARE CENTER

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0036632

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	29-13-100-001-0000	NURSING HOME	\$ 434,119.06	\$ 434,119.06
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 434,119.06	\$ 434,119.06

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

37,547

B. General Construction Type:

Exterior

BRICK

Frame

STEEL

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	132,928	1998	\$ 392,750	1
2					2
3	TOTALS	132,928		\$ 392,750	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	1997		1998		\$ 5,408,525	\$ 138,675	39	\$ 138,675	\$	\$ 780,182	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	24,648	782	31.5	782		10,053	9
10	LEASEHOLD IMPROVEMENTS			1992	28,172	894	31.5	894		10,327	10
11	LEASEHOLD IMPROVEMENTS			1993	11,940	337	31.5	337		3,895	11
12	LEASEHOLD IMPROVEMENTS			1994	4,878	125	39	125		1,169	12
13	TILE / ROOF VENTS			1995	16,191	416	39	416		3,541	13
14	WALL / WATER PANEL			1995	4,199	107	39	107		894	14
15	LANDSCAPING/PARKING LOT REPAIRS			1995	13,614	908	15	908		7,717	15
16	ROOF REPAIRS			1996	13,369	342	39	342		2,615	16
17	SINK			1996	683	18	39	18		135	17
18	ROOF-TOP A/C UNIT			1996	5,100	131	39	131		944	18
19	WINDOWS			1996	1,080	28	39	28		199	19
20	WINDOWS			1997	14,040	360	39	360		2,353	20
21	WALK-IN FREEZER			1997	3,196	82	39	82		523	21
22	WINDOWS			1998	8,370	214	39	214		1,218	22
23	FLOORING / TILE / CARPETING			1998	3,396	87	39	87		492	23
24	CEILING TILES			1998	2,213	57	39	57		297	24
25	ROOF REPAIRS / ROOFTOP A/C			1999	33,838	868	39	868		3,797	25
26	ROOF REPAIRS			2000	13,505	346	39	346		1,341	26
27	INSTALLATION CORNICES & SHEERS			2000	3,280	119	27.5	119		422	27
28	DRAPERY PANELS			2000	2,170	305	20	109	(196)	436	28
29	CARPETING OFFICES			2001	1,814	348	20	91	(257)	273	29
30	INSTALLED ROOF TOP UNIT			2001	6,992	254	27.5	254		519	30
31	LOBBY, NURSES STATION, HALLWAY-FLOORING,CEILING			2003	100,619	2,592	27.5	2,592		2,592	31
32	REMOVAL AND REINSTALLATION OF CUBICLE TRACKS			2003	4,501	900	20	225	(675)	225	32
33	REPLACE FIRE ALARM SYSTEM			2003	5,204	55	27.5	55		55	33
34	NEW DURO-LAST ROOFING SYSTEM			2003	28,200	43	27.5	43		43	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42	COUNTRYSIDE HEALTHCARE CENTER LLC: ROOF	2001	250,900	9,123	39	9,123		20,908	42
43									43
44	CAREPLUS MANAGEMENT INC: LEASEHOLD IMPROVEMENT			138		138			44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,014,637	\$ 158,654		\$ 157,526	\$ (1,128)	\$ 857,165	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 279,915	\$ 25,599	\$ 25,909	\$ 310	3-15	\$ 139,066	71
72	Current Year Purchases	32,685	17,271	1,769	(15,502)	5-10	1,769	72
73	Fully Depreciated Assets	30,609					30,609	73
74	RELATED PARTY ALLOC: SL DEPR		49,286	49,286				74
75	TOTALS	\$ 343,209	\$ 92,156	\$ 76,964	\$ (15,192)		\$ 171,444	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	6,750,596
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	250,810
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	234,490
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(16,320)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,028,609

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$19,692
- Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2002 DODGE RAM	\$682.00	\$8,190	17
18					18
19					19
20					20
21	TOTAL		\$682.00	\$8,190	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	\$
13.	/2005	\$
14.	/2006	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 28,643	\$		\$ 28,643	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			12,704			12,704	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				116,332		116,332	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB	39-2					2,451		2,451	13
14	TOTAL			\$		\$ 41,347	\$ 118,783		\$ 160,130	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (77,302)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 75,000)	4,148,702		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	136,678		6
7	Other Prepaid Expenses	9,452		7
8	Accounts Receivable (owners or related parties)	60,000		8
9	Other(specify): Real Estate Tax Escrow	133,589		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,411,119	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	355,112		15
16	Equipment, at Historical Cost	343,209		16
17	Accumulated Depreciation (book methods)	(345,844)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 352,477	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,763,596	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 581,698	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,102		28
29	Short-Term Notes Payable	1,419,021		29
30	Accrued Salaries Payable	109,112		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,173		31
32	Accrued Real Estate Taxes(Sch.IX-B)	438,460		32
33	Accrued Interest Payable	1,446		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,607,012	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,607,012	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,156,584	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,763,596	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,733,281	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,733,285	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	423,299	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 423,299	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,156,584	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,047,859	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,047,859	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	1,400	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,400	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,049,259	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	924,181	31
32	Health Care	2,075,687	32
33	General Administration	1,657,947	33
	B. Capital Expense		
34	Ownership	1,700,158	34
	C. Ancillary Expense		
35	Special Cost Centers	160,130	35
36	Provider Participation Fee	107,857	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,625,960	40
41	Income before Income Taxes (line 30 minus line 40)**	423,299	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 423,299	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,820	2,045	\$ 73,068	\$ 35.73	1
2	Assistant Director of Nursing	2,003	2,178	62,600	28.74	2
3	Registered Nurses	3,601	3,648	76,068	20.85	3
4	Licensed Practical Nurses	30,143	31,402	607,847	19.36	4
5	Nurse Aides & Orderlies	60,846	67,126	595,433	8.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,591	6,198	56,212	9.07	8
9	Activity Director	1,975	2,079	31,692	15.24	9
10	Activity Assistants	7,832	8,546	61,083	7.15	10
11	Social Service Workers	17,162	18,603	325,702	17.51	11
12	Dietician					12
13	Food Service Supervisor	1,871	1,920	29,757	15.50	13
14	Head Cook	6,541	7,377	71,505	9.69	14
15	Cook Helpers/Assistants	9,941	10,567	73,276	6.93	15
16	Dishwashers					16
17	Maintenance Workers	3,854	4,330	49,804	11.50	17
18	Housekeepers	15,738	17,291	129,644	7.50	18
19	Laundry	8,827	9,775	71,056	7.27	19
20	Administrator	1,717	1,889	79,229	41.94	20
21	Assistant Administrator	1,987	2,068	53,215	25.73	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,684	6,250	105,113	16.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,066	2,255	20,046	8.89	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,709	1,821	48,636	26.71	33
34	TOTAL (lines 1 - 33)	190,908	207,368	\$ 2,620,986 *	\$ 12.64	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 7,200	1-3	35
36	Medical Director	O	2,500	9-3	36
37	Medical Records Consultant	N	2,112	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	1,189	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 27,401		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses		n/a	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
MARIANNE SPRATT	ADMIN	0	\$ 79,229	Workers' Compensation Insurance		\$ 43,882	IDPH License Fee	\$ 200	
MONIQUE MOORE	ASST ADMIN	0	53,215	Unemployment Compensation Insurance		40,277	Advertising: Employee Recruitment	7,882	
				FICA Taxes		197,657	Health Care Worker Background Check	1,308	
				Employee Health Insurance		76,647	(Indicate # of checks performed 94)		
				Employee Meals		#REF!	MARKETING/ADV/PROMO	12,197	
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	150	
				EMPLOYEE BENEFITS - OTHER		5,862	LICENSES & PERMITS	3,267	
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS	10,638	
				PENSION/PROFIT SHARING PLANS		955	MGMT CO ALLOCATION	6,214	
				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(150)	
				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(11,059)	
							Yellow page advertising	(1,138)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 132,444	TOTAL (agree to Schedule V, line 22, col.8)		\$ #REF!	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 29,509
(List each licensed administrator separately.)									
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
CAREPLUS MGMT, INC	MANAGEMENT FEES		\$ 244,000			\$	Out-of-State Travel	\$	
							In-State Travel		
									0
							MGMT CO ALLOCATION		952
							Seminar Expense		
									0

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING	2000	\$ 2,331	3 YRS	\$ 389	\$ 777	\$ 777	\$ 388	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 2,331		\$ 389	\$ 777	\$ 777	\$ 388	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONF TERM CARE \$ 10638
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? NO
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 107,857
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees